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Forecasting Retirement Needs and Retirement Wealth

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Chapter 11

Planning for Health Care Needs in Retirement

Anna M. Rappaport

Support for health and long-term care expenses is vitally important to an understanding of retirement needs and resources. Among the challenges we face in this area, as a nation, is the fact that many people in the 55–64 age group have no satisfactory access to health care insurance and medical care coverage. In the past, employers were a major source of coverage supplementing Medicare, but over time they have gradually reduced their commitment to retiree health insurance. Changes in the private health care marketplace will also alter medical care and insurance options available to individuals and employers in the future. In addition, Medicare costs are projected to increase markedly as the baby boom generation ages, and the Medicare system will confront insolvency within the next decade.

Making the situation more complex is the fact that the elderly have high levels of out-of-pocket medical spending, making healthcare a major concern for the poor and nearly poor elderly. This is tied to the fact that healthcare needs rise with age, and many elderly are frail and require a wide range of help. This chapter examines how the elderly in the United States cope with healthcare problems at present, and it also evaluates several programs which help provide coverage among the older population. In doing so, we explore the roles of both employers and the government in providing medical care for the older population, and we discuss policy options for the future.

Health Care Costs and Utilization by Age

Utilization of health care services rises with age, a pattern confirmed by data on spending by consumer units for health care. Table 1 shows how medical spending varied with age in 1994 in the Consumer Expenditure Survey. At

TABLE 1: Average Consumer Expenditures for Health Care per Customer Unit (1994)

Age of Reference Person	*Total ($)*	*Total Expenses ($)*	*Health Insurance ($)*	*Medical Services ($)*	*Drugs and Medical Supplies ($)*
Under age 25	$ 505	2.7	$ 186	$ 218	$ 102
25–34	1,086	3.6	479	407	199
35–44	1,616	4.3	689	627	299
45–54	1,855	4.5	772	673	410
55–64	2,144	6.4	895	791	459
65–74	2,592	10.3	1,467	539	586
75 and over	2,787	14.4	1,496	639	653
Average for all ages	1,755	5.5	815	571	369

Source: U.S. Bureau of the Census (1996).

lower ages, healthcare costs are influenced by employer health coverage, whereas for people age 65 and over, healthcare costs reflect the availability and coverage of Medicare benefits and payments. The costs described in the table are in addition to what is paid for by taxes under Medicare and by what is financed by employers.

The evidence also demonstrates that older groups are more heavily female, the result of the fact that men suffer shorter life spans. Elderly females are also more likely to be widowed, whereas elderly males are much more likely to be married (see Weir and Willis, this volume).

Medical care costs for older persons are shared among Medicare, the individual, and employer plans. Employer costs are higher prior to Medicare eligibility, because Medicare pays much of the cost of retiree health after age 65. Average premiums for retiree health plans reported in a Mercer/Foster Higgins National Survey (1997) of employer-sponsored health plans were $5,000 per year for retirees younger than age 65 and about $1,900 per year for Medicare-eligible retirees.

Prescription drugs constitute a major source of out-of-pocket and employer spending for older persons. About half of Medicare beneficiaries living in the community (that is, not in nursing homes) reported that they had prescription drug coverage in 1994; the fraction reporting coverage is shown by age in Table 2. Sources of prescription drug insurance for those reporting coverage are shown in Table 3. Here we see that 59 percent report employer coverage, 29 percent report coverage from Medicaid, and 12 percent had Medigap coverage. Evidently, a major weakness of many Medigap plans is the lack of drug coverage.

Health care costs and utilization increase with age for adults. Total costs are quite difficult to measure, however, because cost information is typically

TABLE 2: Medicare Beneficiaries Having Prescription Drug Coverage by Age (1994)

Age Group	*Percent Reporting Drug Coverage (%)*
Under 65	62
65–74	54
75–84	47
85 and over	44

Source: Gross and Brangan (1997).

TABLE 3: Sources of Prescription Drug Coverage for Those Reporting Coverage (1997)

Source	*Percent Reporting Source (%)*
Medicaid	29
Employer plan	59
Medigap	12

Source: Gross and Brangan (1997).

maintained by payor rather than aggregated for a given individual or household. Differences in payment methods and payors also complicate the measurement of costs. For people covered by capitated plans, it is sometimes difficult to define what cost is beyond the premium. A capitated plan is one where the plan receives a set premium to provide health care rather than being reimbursed for services provided. The premium is the same regardless of what services are used. Utilization and underlying services provided vary greatly by individual. Premiums, of course, reflect an average cost for the covered group.

Another factor making it difficult to measure healthcare costs by age is that the charge for a hospital or physician service may vary greatly depending on who the payor is. Payors include Medicare, Medicaid systems, health plans, and individuals without coverage. Differences are due to differences in contracts between the payors and different providers. Table 4 shows estimated healthcare costs for the elderly by age group (Moon 1996). These estimates indicate that for Americans age 65 and over, out-of-pocket costs averaged 30 percent of income for those whose incomes were 150 percent of the poverty level or less. Costs increased by age both as a dollar amount and as a percentage of income. Females were also heavily represented among the poor, the nearly poor, and the very elderly. Out-of-pocket spending patterns by the elderly appear in Table 5. About half of spending is for Medicare Part B and supplement premiums and the balance is for cost-

TABLE 4: Health Costs for the Elderly by Demographic Group (1996)

Characteristics	*Average Individu-alHealthcare Spending ($)**	*Average Out-of-Pocket on Medicare Services ($)*	*Average Medicare Expenditures*	*Average Family Out-of-Pocket Costs as % of Family Income*
Poverty Status				
Under 100%	1,921	298	5,894	30
100–150%	2,603	623	5,975	30
150–200%	2,716	683	5,014	26
200–400%	2,705	707	4,354	18
Over 400%	2,817	776	3,897	11
Age				
65–69	2,326	559	3,952	18
70–74	2,421	586	4,535	20
75–79	2,625	748	4,587	22
80–84	3,256	810	6,220	25
85+	3,412	637	7,132	25
Gender				
Male	2,491	633	4,383	18
Female	2,686	657	5,013	22
All elderly	*2,605*	*648*	*4,753*	*21*

Source: Moon (1996).
*Captures total out-of-pocket spending and spending on Medicare Part B premiums and private insurance premiums.

TABLE 5: Out-of-Pocket Spending for Health Care by the Elderly, by Type of Expense (1996)

Type of Spending	*Type (%)*
Private insurance premiums	31
Medicare Part B premiums	18
Medicare cost-sharing	25
Uncovered items*	26
Total	100
Average Out-of-Pocket Spending = $2,605	

Source: Moon, Kruntz, and Pounder (1996)
Note: Data are for the noninstitutionalized elderly population only.
*Medical care not covered by Medicare such as outpatient prescription drugs, eyeglasses and hearing aids.

TABLE 6: Annual Physician Contacts By Age and Sex

	1987	*1990*	*1992*	*1994*
Male	*4.6*	*4.7*	*5.1*	*5.2*
Under 5 years	6.7	7.2	7.1	7.0
5–14 years	3.4	3.3	3.5	3.5
15–44 years	3.3	3.4	3.7	3.7
45–64 years	5.5	5.6	6.1	6.3
65–74 years	8.1	8.0	9.2	10.1
75 years and over	9.2	10.0	12.2	11.6
Female	*6.0*	*6.1*	*6.6*	*6.7*
Under 5 years	6.7	6.5	6.7	6.5
5–14 years	3.1	3.2	3.3	3.3
15–44 years	5.8	6.0	6.2	6.2
45–64 years	7.2	7.1	8.2	8.3
65–74 years	8.6	9.0	10.1	10.5
75 years and over	10.0	10.2	12.1	13.4

Source: Centers for Disease Control and Prevention (1996–97).

TABLE 7: Respondent-Assessed Health Status by Age and Sex

	Fraction in Fair or Poor Health (%)			
	1987	*1990*	*1992*	*1994*
Male	*9.0*	*8.4*	*9.4*	*9.0*
Under 15 years	2.5	2.6	2.9	3.1
15–44 years	4.5	4.5	5.7	5.4
45–64 years	16.6	15.5	16.5	15.3
65–74 years	28.9	25.0	26.8	26.6
75 years and over	36.0	31.7	33.5	31.9
Female	*9.9*	*9.3*	*10.1*	*10.1*
Under 15 years	2.3	2.2	2.7	2.7
15–44 years	6.3	6.3	7.2	7.4
45–64 years	18.1	16.5	17.8	17.7
65–74 years	27.7	25.1	24.7	24.9
75 years and over	34.2	31.6	33.0	30.8

Source: Centers for Disease Control and Prevention (1996–97).

sharing and uncovered items. Prescription drugs can be a very costly item for persons requiring regular medication.

To help understand the relationship of spending to age, it is important to focus on utilization, which indicates how often a given type of service is utilized by age group. Gross and Branagan (1997) report age-specific rates

TABLE 8: Limitation of Activity Caused by Chronic Conditions by Age and Sex (%)

	Total with Limitation of Activity		*Limited But Not in Major Activity*		*Limited in Amount or Kind of Major Activity*		*Unable to Carry on Major Activity*	
	1990	*1994*	*1990*	*1994*	*1990*	*1994*	*1990*	*1994*
Male[1]	*12.9*	*14.3*	*3.8*	*4.2*	*4.7*	*5.3*	*4.4*	*4.8*
Under 15 years	5.5	7.6	1.4	1.8	3.6	5.0	0.5	0.8
15–44 years	8.4	10.1	2.3	2.8	3.5	3.9	2.7	3.4
45–64 years	21.4	21.3	4.7	4.6	6.6	6.9	10.1	9.9
65–74 years	34.0	34.7	13.0	13.3	8.4	8.5	12.7	12.8
75 years and over	38.8	40.7	20.3	21.6	10.2	10.2	8.3	8.9
Female[1]	*13.0*	*14.3*	*4.3*	*4.6*	*5.3*	*5.7*	*3.4*	*4.0*
Under 15 years	3.9	5.1	1.0	1.4	2.5	3.1	0.4	0.6
15–44 years	8.7	10.1	2.9	3.5	3.6	4.0	2.2	2.6
45–64 years	22.2	23.9	6.6	6.4	8.4	8.8	7.2	8.6
65–74 years	33.5	33.5	13.4	13.2	11.1	11.2	8.9	9.2
75 years and over	46.0	46.2	17.9	17.3	17.7	17.1	10.4	11.7

Source: Centers for Disease Control and Prevention (1996–97).
[1] Age adjusted.

of annual days of hospital care per 1,000 population. For example, the population average was 544 for all ages in 1995, but among those aged 65–74, the average hospitalization rate per year was 1,669 days, and for persons age 75 and over, it was 3,220 days annually. While the number of hospitalization days per 1,000 population has dropped steadily over time, it remains true that older people are hospitalized more often. Moreover, there has been an increase in the relative utilization at the very oldest ages. For example, people at ages 75+ use six times the average number of days of hospital care in 1995 as compared to the overall population, versus five times as much in 1980.

It is sometimes noted that physician contacts rise with age; this is confirmed in Table 6. Here we see that age and utilization of physicians is higher among the old, though the pattern is not as pronounced as for hospital days. The increase in physician contacts rises by 15 percent between age 65–74 to age 75+, whereas the number of hospital days approximately doubles between the two age groups. These data on healthcare utilization are consistent with other information on health status and activity limitations, which also paints a picture of declining health and increasing activity limitations with age. For instance, Table 7 shows changes in respondent-assessed health status by age between 1987 and 1994, while Table 8 shows activity limitations by age caused by chronic conditions. Respondents age 70+ are about 20 percent more likely to report fair or poor health when

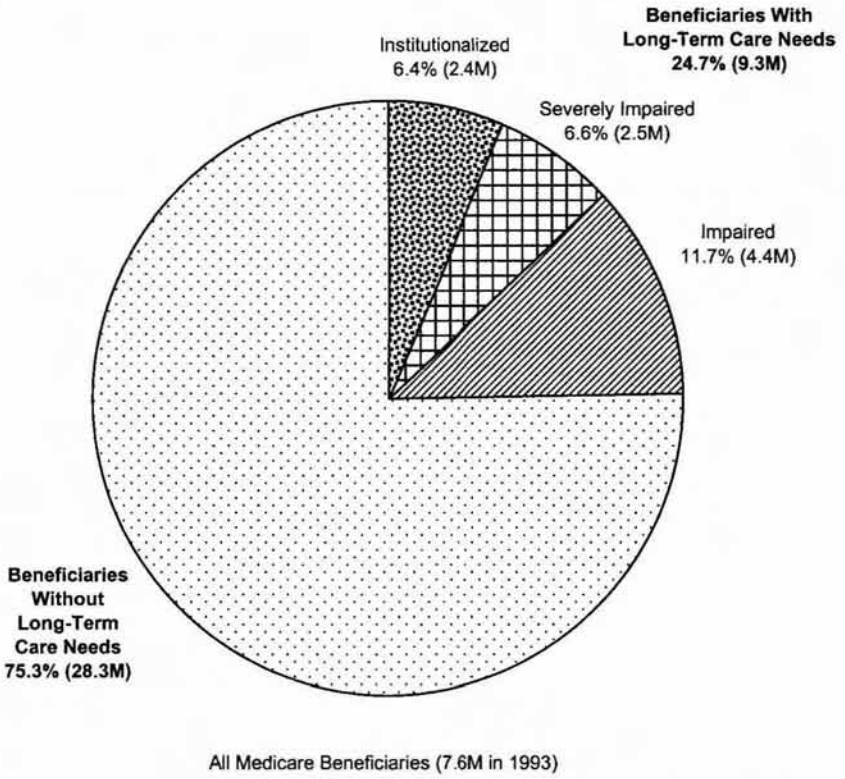

Figure 1. Distribution of Medicare beneficiaries by long-term care needs, 1993. "Institutionalized" means residing in a short- or long-term care facility. "Severely impaired" and "impaired" refer to community-based beneficiaries with respectively three or more or one or two limitations in activities of daily living (ADLs) — bathing, dressing, walking, eating, toileting, or getting out of a chair. Source: Feder and Lambrew (1996).

compared to those age 65–74, and they report being in fair or poor health more than three times as often as the population as a whole. Elderly males report poor health slightly more often than elderly females, whereas among younger adults, females report poor health more often than males.

Long-term care needs also rise with age, where by long-term care we refer to nursing home usage. Figure 1 shows the distribution of Medicare beneficiaries by long-term care needs and indicates that 25 percent of this population had some type of long-term care needs in 1993. All of these data are consistent with rising needs and utilization with increasing age.

The Role of Employer Coverage in Providing Retiree Health Care Benefits

Larger employers in the United States have traditionally offered healthcare benefits to their retirees. Most often, a firm will impose a minimum age and years of service requirement for retiree health. Also, in many plans, retirees have had to share in the cost of the coverage. Retiree health coverage is important in retirement decisions, particularly for people retiring before age 65. One employer survey found that the average retirement age was 64 in organizations not offering retiree health coverage, versus 61 in those organizations that did offer retiree health (Mercer/Foster Higgins 1996).

Employers began to offer health care benefits during and after World War II, particularly in firms with unionized workforces. At that time, coverage for retirees was included in many plans without much consideration of the long-term cost consequences. At their inception, these plans were not particularly expensive, and the number of retirees was usually low. Of course, the demographic and economic consequences of population aging have changed all this today. Healthcare benefits for workers of all ages are now much more expensive, and cost considerations are a priority issue for businesses both large and small. As a result, healthcare benefits have been reduced recently, and coverage for active as well as retired employees is falling off (Table 9). Companies that were once large have downsized, and many of them have more retirees than they do active employees. While this is still unusual and not the norm, it is very common to have substantial numbers of retirees in mature organizations.

During the 1980s, private sector accounting standards for retirement-related benefits changed in important ways in the United States. Pension plan accounting standards changed first, and then retiree health benefits were included in the discussion about retirement benefit accounting. New rules were adopted for retiree health benefits accounting in Statement of Financial Accounting Standards Number 106, which for the first time treated retiree healthcare benefits like a pension benefit. Thus the anticipated costs of retiree health had to be recognized over the working lifetime of employees. These rule changes, together with increases in the costs of medical care and a number of demographic trends, produced costs which were a financial shock to many corporate managers. When these firms first assessed their retiree health costs and liabilities, many were forced to implement substantial changes in their benefit plans. These changes included limits on eligibility, benefit cuts, raising retiree contributions, and plan changes including the introduction of managed care (see Table 10). In some cases, retiree health benefits were discontinued, at least for future retirees or new entrants.

These upheavals in the accounting and medical marketplace produced a

TABLE 9: Employers Offering Retiree Health Coverage (%)

	1984	*1991*	*1997*
Midsize firms (200–999 workers)	51	44	33
Large firms (1,000–4,999 workers)	77	56	49
Jumbo firms (5,000+ workers)	91	72	66
Overall	67	46	37

Source: KPMG Peat Marwick (1996).

TABLE 10: Employer Cost Sharing for Retiree Health Insurance (%)

	Contribution Strategies for Retirees Under Age 65	*Contribution Strategies for Medicare-Eligible Retirees*
Employer pays all	20	27
Cost is shared	49	47
Retiree pays all	31	27

Source: Mercer/Foster Higgins (1997).

marked decline in health care coverage for both active and retired workers. This downward trend in coverage clearly contributed to the increase in the nation's uninsured population (EBRI 1997). For example, about 18 percent of Americans younger than age 65 had no health insurance in 1996, and the fraction of uninsured Americans under age 65 has been increasing over time. Much of this increase was due to the increase in uninsured children. Factors such as citizenship, employment, industry, firm size, income, race, age, and the number of children are important determinants of whether an individual has health insurance. For example, 44 percent of non-citizens under age 65 had no insurance, compared with 15 percent of citizens. Most uninsured workers were found in retail, service, or manufacturing industries, small private sector firms, or were young.

While most large U.S. employers do still offer healthcare coverage to retirees, those employers that do so have increased cost sharing and adopted several other measures to trim costs and control liabilities. Of employers offering plans, few pay the full cost for both pre-Medicare and post-Medicare retirees. Mazo, Rappaport and Schieber (1993) found that, over the years, companies have tightened eligibility for retiree health coverage using higher age and service requirements, and financial caps were placed on future retiree health obligations. In addition, managed care plans for retirees have grown increasingly popular. Therefore we conclude that employers have reduced their role in providing retiree health benefits, though they continue to play a significant role overall.

Retirees Lacking Employer Health Insurance Coverage

Retirees who do not have employer coverage are in a very different situation, depending on whether or not they are Medicare eligible. Medicare is currently made available to most Americans attaining the age of 65, and it is also provided to the severely disabled after a waiting period of 30 months. For those who are eligible, Medicare covers most hospital and physician care and a number of other services. However, the program does not presently cover prescription drugs, eye glasses, and hearing aids; various other services are also excluded. Medicare plans also typically require deductibles and co-payments. Despite these forms of co-insurance, Medicare covers a very substantial portion of older people's acute care medical costs. Many older persons also purchase so-called "Medigap" policies on the private marketplace, which provide supplemental coverage to fill in Medicare's gaps. Those who buy coverage when first eligible cannot legally be denied thereafter on the basis of health.

A very different situation prevails for a retiree or spouse who is not Medicare-eligible, since it is very costly for older people to purchase individually-sold health insurance coverage. Though some people can obtain this type of health insurance coverage, the policies generally require strict underwriting rules so that those in poor health either cannot get coverage or must pay very high prices. Some states offer special pools for the uninsured, or have mandates requiring insurance companies to cover anyone who applies. The 1996 Health Insurance Portability and Accountability Act (HIPAA) legislation limits pre-existing condition restrictions for persons who had prior coverage. It is unclear whether this will help early retirees or how much market there will be allowing them to buy individual coverage. However, the regulations permit charging a high price overall, and individuals buying coverage as HIPAA-eligibles are likely to pay a higher price for the coverage than those who buy underwritten individual coverage.

Healthy individuals have better options than those who are chronically ill. My own practice has shown that monthly premiums for health insurance by age vary between $330 and $465 per month for an individual in good health. These are premiums for a plan requiring a $250 deductible with 80 percent coinsurance and a $2,000,000 lifetime maximum (in 1998). Pre-existing conditions are not covered for 12 months.

Where Long-Term Care Fits In

Today, one-quarter of Medicare beneficiaries today require some type of long-term care support, as shown in Figure 1. Approximately 11 percent of the elderly age 65–74, 27 percent of those age 75–84, and 60 percent of the elderly over age 85 are disabled in some way and need help. There is a wide

TABLE 11: Monthly Premiums for an Individual in Good Health Purchasing Insurance ($)*

Age	*Male*	*Female*
55	$370	$330
60	430	360
63	465	375

Source: Author's tabulations of unpublished data, William M. Mercer (1997).
* $250 deductible, 80 percent coinsurance, $2,000,000 lifetime maximum.

TABLE 12: Comparison of Supportive Housing Types

	Typical Number of Residents	*Services*	*Cost per Month*	*Other*
Board and care	2–200	Some ADL and IADL	$500–$3,000; many low-cost; half publicly supported	Most diverse in quality, size, and cost
Assisted living	15–100	ADL and IADL	$1,000–$3,000; typically private pay	Philosophy of independence promotes aging in place
Adult foster care	1–8	Some ADL and IADL	$600–$1,500; at least half publicly supported	Small, family-like
Continuing care retirement communities	100+, independent; 30+, assisted living; 30+, nursing home	Varies by buildings within the community	$900–$3,600 (varies by level of entrance fee); typically private pay	Independent is similar to congregate care; assisted living in CCRCs is similar to other assisted living
Congregate care	100+	Hotel-type services, such as meals and light housekeeping	$700–$1,500; typically private pay	Apartment buildings with some common services

Source: Hudson (1997).

variety of different needs for help, depending on the type and degree of disability. Generally, medical insurance and Medicare do not cover such help (other than medical services). Today, most such help is provided informally in the community by family and friends.

New housing options are also emerging which combine increasing levels of support with residential services. "Assisted living" options are emerging in many locations, a term that combines a residential environment and

(depending on state regulation) supportive services. By 1996, 30 states had created an assisted living licensure category, passed legislation authorizing such a category, or covered assisted living as a Medicaid service (Mollica 1997). Table 12 compares five types of supportive housing. It shows a range of costs and services, providing much broader options than simply nursing homes or independent living.

The Managed Care Marketplace

The health care insurance marketplace has undergone substantial changes in recent years. Over the last decade, many employers have encouraged employees and retirees to choose managed care options. For example, the insured population in fee-for-service plans dropped from 59 percent in 1992 to 35 percent in 1995 (EBRI 1997: 243). Nevertheless, as the popularity of managed care options has grown, there has also been some backlash against the guidelines and practices that health maintenance organizations use to manage costs. Millenson (1997: 11) provides a perspective on this transition:

> Not so many years ago, the managers of health maintenance organizations (HMOs) were regarded as wild-eyed socialists seeking to undermine fee-for-service medicine. Now, like aging sixties radicals who have traded in a peace sign for a profit-and-loss statement, HMO managers stand accused of acting like health care robber barons who skim off profits for themselves by scrimping on services for their members. Yet despite the heated rhetoric, some sixty million generally contented Americans were members of HMOs by the end of 1996. For better or worse, HMOs have become the tool that employers and (increasingly) Medicare and Medicaid have chosen for the nearly impossible task of attempting to ration care while keeping everyone happy.

While the HMOs have become a target for legislative action limiting their right to ration care, this has been limited to specific cases thus far. Maternity stays are an example (which usually does not affect the elderly), and federal legislation has mandated minimums for permitted maternity stays. More legislation is likely, as we shall see below.

Other developments also portend changes in the medical care insurance market. Several managed care companies had poor financial results in the late 1990s, as the costs of providing coverage to Medicare-eligible populations proved higher than expected. This industry, like many others, has had substantial consolidation in recent times, and there are relatively few important major players. It also appears that major HMOs may cut back their commitment to Medicare risk contracts. Under such contracts, an HMO is paid a predetermined amount that varies by geography, for providing care to Medicare patients. The plan generally offers a more generous program to the individual, and provides extra benefits over fee-for-service Medicare. Four major HMOs, namely Aetna, United Health Care, Oxford Health, and PacifiCare Health, have recognized problems linked to Medicare con-

tracts by trimming new plan features in some way. For example, Aetna U.S. Healthcare withdrew from its Medicare HMO business in six states and selected counties, impacting 58,000 seniors (it will continue to operate in 16 states, covering just under a half million individuals). United HealthCare Corporation disclosed in mid-1998 that it would take a $900 million charge to reflect losses. Oxford Health and PacifiCare trimmed offerings and face continued troubles. Oxford's stock stood around 75 in 1997, falling to around 6 a year later as a result of its troubles. Each of these examples indicates that the healthcare marketplace is volatile and full of uncertainty.

As a result of these marketplace challenges, some of the previously generous Medicare HMO benefits have had to be trimmed. Some programs had previously offered extra benefits over Medicare, including prescription drugs, and in some cases, eyeglasses and dental care; now benefits have been reduced, and premiums added (Freudenheim 1997). These developments within the healthcare industry are also likely to impact employers sponsoring plans for actives and retirees, individuals purchasing coverage, and "Medicare+Choice" programs. In the case of Medicare+Choice programs, premiums charged to beneficiaries are likely to be higher and/or additional benefits beyond the minimum Medicare benefit are likely to be lower. At the same time, there is an increasing public backlash against managed care plans. Legislation and regulations are likely to restrict managed care plans from freedom to establish their own rules.

Policy Options

While numerous policy options are potentially available, the shape of health reform as it affects the elderly will be powerfully shaped by some recent key events. These include the Balanced Budget Act of 1997, health care proposals made by President Clinton in 1998, and changes anticipated in the health care marketplace.

The Balanced Budget Act of 1997

This Act provided for a number of changes to Medicare in order to help achieve a balanced budget by 2002. Cost reductions of $15 billion were partly offset by $10 billion in new preventive services. Several major changes were as follows:

Prospective payment systems expanded. Several areas were added to the prospective payment system, including hospital outpatient services, skilled nursing, home health, rehabilitation, and ambulance services. Under prospective payment, Medicare pays a flat fee based on diagnosis rather than reimbursing based on specific services provided. This shift will reduce the growth in these costs and bring them under much better control.

Part B premiums increased. Retirees currently pay for part of their Medicare

benefits through premiums for Medicare B. Increasing such premiums shifts costs to retirees and reduces the tax-funded cost of the program.

New program provides for expanded choice. Under this program, called Medicare+Choice, Medicare will make a fixed payment to the plan which will then assume the risk. The types of plans under Medicare+Choice will include Coordinated Care Plans, private fee-for-service, and medical savings account plans. Prior to the Balanced Budget Act, HMOs could take risk under Medicare and such programs were increasing their market share, but other Medicare coverage was on a fee-for-service basis. These changes greatly expand the types of marketplace options available to individuals. It is anticipated that this program will shift many more beneficiaries into alternative programs. With the new options, there is to be a regular program permitting annual re-enrollment and providing beneficiaries information about all of the options. The Federal Employees' Health Benefits Program is supposed to be the model for this program.

Method changed for calculating the payment to risk programs. Under the prior law, payments to risk plans were based on the fees charged in the fee-for-service programs in the geographic area where the program was provided. This method of reimbursement produced excessive reimbursements in some areas, and very low reimbursements in others. In the areas with high reimbursements, there were very generous HMO offerings which included added benefits at no cost to the participant. In many areas with low reimbursements, there were no HMO offerings. The new method will gradually equalize payment, slow the rate of increase in payments, and increase the payments in low reimbursement areas.

Reduced reimbursement to health care providers. About half of the $115 billion savings in Medicare from the Balanced Budget Act changes is the result of changes in reimbursement to providers.

The Administration's Medicare Reform Proposals

Recent proposals to reform Medicare include plans to: (1) permit people age 62–64 to buy in at a cost of approximately $300 per month, with an added premium after age 65 to make up for costs over $300 per month per person, (2) extend COBRA to Medicare eligibility age for people terminating employment after age 55, and (3) permit the unemployed age 55 and over to buy into Medicare for approximately $400 per month per person. Though the details of these proposals have not yet emerged, it appears likely that the Republicans will oppose reforms of this type.

Potential Impact on the Poor

In the past, the Medicaid system has been a source of health care coverage of last resort for the poor. Medicaid systems, though they differ across states,

provide for payment of Medicare Part B premiums; their benefits also help fill in for uncovered items, deductibles, and copayments for the poor. A danger that must be recognized is that changes in Medicare benefits put pressure on Medicaid payments, which may result in changes in Medicaid programs too. Currently Medicaid pays for about half of long-term care charges, and population aging will stress Medicaid at the same time that it puts pressure on Medicare. If benefits from both programs are cut, the poor may be much worse off.

Longer-Term Issues

Longer-term problems within the Medicare system remain, despite reforms enacted under the Balanced Budget Act of 1997. Out-of-pocket spending for medical care by the elderly is as high today as it was before Medicare was adopted in 1965. This implies continuing pressure to raise benefits. Yet projected tax allocations are inadequate in future years. In addition, the system is viewed as inefficient, when compared to managed care in the private sector. Another issue, not yet resolved, is that some people on Medicare purchase excessive coverage for the "gaps" in their insurance, while early retirees and spouses not yet eligible for Medicare without employer coverage have to pay a great deal for medical coverage. Often people cannot obtain satisfactory coverage if they are in poor health. These measures are exacerbated by demographic aging of the population.

In the near future, decisions will have to be made with regard to several policy issues, including the following:

Medicare Eligibility Ages

Currently, Medicare benefits are available at age 65. Social security eligibility ages in the future have already been modified, so that for persons born in 1960 and later, full benefits will be available at age 67. The higher age for full benefits is being gradually phased in. Earlier versions of the Balanced Budget Act would have aligned the Medicare eligibility age with the social security age. Such a change would have had a significant cost impact on employer plans, and presented additional problems of access to individuals without employer coverage. Life spans have clearly increased since the program was introduced in 1965, and this change seems logical in that light. Since this proposal, there has been a new proposal to reduce eligibility ages by permitting a voluntary buy-in prior to age 65. This entire area demands careful policy analyses.

Private sector options. Via the 1997 Balanced Budget Act, the government is now seeking to move retirees into private sector healthcare plans. At the same time, the healthcare industry is consolidating and having a difficult time remaining profitable. Reimbursement rates to capitated Medicare

plans have been curtailed, while at the same time there is growing pressure to force plans to provide more services. Some have proposed legislating a "Patient's Bill of Rights," outlining access to treatment options and providers. All these changes challenge older people's access to care by potentially raising premiums.

Pre-65 coverage. Many Americans leave employment prior to age 65 without health coverage, either as a result of retirement, a move to self-employment, or a move to a job without coverage or the loss of a job. President Clinton's 1998 State of the Union Address proposed offering a Medicare buy-in to individuals who are 55 or over and do not have health insurance coverage. If such a buy-in were elected by those who are sicker—and, if enacted, this seems very likely—such a buy-in would impose additional costs on the Medicare program. A major problem with the plan is that it seems unlikely that the chronically ill and sicker among this group would be able to afford to pay for their own health care costs. This is a highly difficult issue, one that has been joined to the Medicare debate by the President's proposals.

Level of spending by beneficiaries. One method to reduce Medicare costs is to shift costs to beneficiaries, either through higher contributions or higher deductibles and copayments. Yet poor beneficiaries are already spending 30 percent of their income on out-of-pocket health care costs. Those whose income is four times the poverty level or greater are spending about 11 percent of their income. Cost shifting seems very harsh except for wealthier beneficiaries.

Options for Employer Plans

As has been demonstrated, employers' commitment to retiree health and to all kinds of career-based retirement benefits has fallen in the United States. This pattern may indicate that the social contract between employers and employees is gradually changing. Thus there are now few organizations where lifetime employment is expected, and benefit plans are changing in tandem. Specifically, employers have increasingly shied away from assuming open-ended risks in employee benefit plans. In light of uncertainty about Medicare, changes in medical technology, and life spans, the potential costs for retiree health are very uncertain. On the other hand, employers do not want long-term employees to feel vulnerable, and the lack of a marketplace where individuals can buy reasonably priced pre-65 health insurance has left many employers feeling that they have little choice but to take this risk. As a practical matter, HIPAA has not changed this situation. There is no real market for the employer to "insure" this risk on a long-term basis, so employers are bearing the risk. Where the risk is insured on a short-term basis, coverage availability is not guaranteed from year to year and the insurance is generally heavily experience rated.

Future legislation may powerfully change the dynamics of the situation.

For example, if a Medicare buy-in were available, it is possible that some employers would drop coverage or simply provide funds to help with the premium payment. Current law known as COBRA mandates that health insurance coverage continue for 18 or 36 months after a worker leaves his firm, depending on the reason for termination of coverage. If COBRA were modified to mandate longer coverage continuation to age 65, this would also change the dynamics from an employer perspective. One proposal, for instance, would mandate COBRA coverage and require that the premium charged would not exceed 125 percent of the average cost of the coverage. This amount would be a burden for many retirees, and employers would probably experience severe anti-selection with the people electing the coverage being either the relatively more affluent or those in poorer health. COBRA changes would mean that the employer had liability for a much larger group of people, since many people leave without enough service to be eligible as early retirees for retiree coverage. Future legislative proposals are likely to be highly controversial.

Another trend observed in the labor market is that employers feel it appropriate to shift responsibility for retirement wellbeing to the individual. The employers will still provide dollars and vehicles to help employees, but few will adopt the "we will take care of you" stance of the once entitlement-minded employers. This change in perspective explains the downward trend in retiree health coverage. It is paired with increased mobility, and such shifting employment patterns imply that fewer people will be eligible for these benefits as they reach age 65. This is the result of more employment in smaller firms and anticipated shorter durations of employment.

Employer support for health coverage is powerfully influenced by tax policy. Today health benefits can be provided on a tax-free basis to both active employees and retirees. A plan sponsor is not required to provide equal benefits to all employees or all retirees, and the plan can be designed to target groups in various ways. A change in the tax treatment of active or retiree health benefits could dramatically alter such benefit offerings. At this juncture it seems unlikely that tax reform will be enacted which will remove the preferential treatment of health benefits.

Conclusion

There remains substantial uncertainty over the issues that will influence future health care costs, health care insurance in the future—and particularly employer and government health care policy. Several predictions may nevertheless be offered. First, Medicare is unlikely to undergo one sweeping reform to reestablish its financial footing; rather it will experience multiple changes over a five to ten year period (if not longer). Second, it seems probable that employer commitment to health insurance will continue to

decline through increases in cost sharing, redesign of plans, and perhaps, benefit cuts. For people needing health insurance coverage prior to age 65 (when they become Medicare eligible), changes in Medicare and/or COBRA could influence employer behavior to a great degree. For post-65 coverage, we expect to see a substantial shift to retiree premium plans, where the employer offers a reimbursement account for insurance premiums and the retiree is permitted a wide choice of insurance options at a group rate. Nevertheless, in the absence of legislative change, pre-65 health insurance access will continue to be available through many employer retiree healthcare plans. This makes it absolutely critical for people to recognize and assess likely high and rising costs of health care as they look ahead into retirement, and also to increase their savings to help insure they have health care coverage at older ages.

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